Department of Medical Assistance Services
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www.dmas.virginia.gov

# MEDICAID MEMO

**TO:** All Psychiatric Service Providers, Acute Care and Psychiatric Hospitals, Level C Residential Treatment Facilities, Level A and Level B Group Homes, EPSDT Residential Treatment Providers, Magellan and Managed Care Organizations

**FROM:** Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

**MEMO:** Special
**DATE:** 6/1/2017

**SUBJECT:** New Program Manual for Residential Treatment Services and Changes to the Independent Certification of Need Process

The purpose of this memorandum is to announce changes to Residential Treatment Facility (Level C), Community-Based Residential Services for Children and Adolescents under 21 (Level A) and Therapeutic Behavioral Services (Level B). The Department of Medical Assistance Services (DMAS) has developed a NEW Residential Treatment Services Manual, which updates program criteria and program rules that will go into effect on July 1, 2017. This new Residential Treatment Services Manual will supersede program criteria and rules as defined in the existing Chapter 4 "Covered Services and Limitations" sections of the Psychiatric Services and Community Mental Health Rehabilitation Services (CMHRS) manuals. The service name for Level C residential treatment centers is being changed to Psychiatric Residential Treatment Facilities (PRTF) and the Level A and Level B Residential services will now be labeled as Therapeutic Group Home (TGH) services. Significant changes, projected to improve the care experiences for youth and families, will include:

1) Revised program requirements for psychiatric residential treatment services;
2) Revised program requirements for therapeutic group home services;
3) New program requirements for Early Periodic Screening, Diagnosis and Treatment (EPSDT) psychiatric residential treatment and therapeutic group home services;
4) Enhanced family engagement and discharge planning requirements to begin upon admission;
5) A planned elimination of the Level A group home level of care; and,
6) Revised processes for assessment of youth and family needs, certification of medical necessity for residential treatment services, and care coordination.

Changes are designed to transition existing services into models of care with evidence based treatment approaches, standardized medical necessity criteria, and rigorous program requirements to create a youth and family-focused system that will match future managed care administration structures, oversight, and contracting requirements. Regulatory changes are also necessary to enable implementation of program reforms and to ensure Virginia's compliance with federal regulations for Medicaid (federal) matching dollars.

The Residential Treatment Services Provider Manual is posted on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx for public comment through June 16, 2017. Please send comments by June 16, 2017 to: *RTCChange@dmas.virginia.gov*

The Residential Treatment Services Provider Manual will be finalized and officially posted by June 30, 2017 at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

**Level A Group Home Level of Care** (Service will end in 2018)

Regulations that were effective until June 30, 2017 established three levels of residential care, i.e., Level A Group Home, Level B Group Home, and Level C Psychiatric Residential Treatment Facility. Research of the licensing requirements of Department of Behavioral Health and Developmental Services (DBHDS), Department of Social Services (DSS) and Medicaid regulations indicates that DSS licensed Level A Group Homes will no longer be eligible for continued Medicaid reimbursement. Medicaid regulations require therapeutic group home programs to provide counseling services and therapeutic interventions. These therapeutic interventions are not an allowable service under the DSS licensure for Level A Group Homes.

Revised regulations establish two levels of residential care, i.e., PRTF and TGH. Both levels of care require licensure by DBHDS.

In order to better align service delivery with federal mandates and licensing requirements, Level A group homes who wish to provide Medicaid covered services must obtain a license from DBHDS to provide Medicaid reimbursed therapeutic group home services. As of February 1, 2017, Magellan, the Medicaid Behavioral Health Service Administration, stopped enrolling new Level A providers with licenses issued by DSS. Current Level A providers who are contracted with Magellan have until April 30, 2018 to obtain a conditional license as defined by DBHDS in 12VAC35-46-90. **As of May 1, 2018 DMAS will no longer reimburse for therapeutic group home services provided by a DSS licensed facility.**

Providers should note that the DBHDS licensing process may take up to 12 months. Level A Providers were instructed in the DMAS Program Manual update of December 9, 2016, to contact DBHDS to indicate their interest in applying for licensure by February 1, 2017. On January 20, 2017 DBHDS conducted an information session to outline the transition process for Level A provider to become licensed as a Therapeutic Group Home. Licensing Applications are due to DBHDS by June 30, 2017.

**Independent Assessment, Certification and Coordination Teams (IACCT)**

Federal Medicaid regulations require, per 42 CFR (Code of Federal Regulations) § 441.153, that an independent certification team assess the needs of a youth to determine the appropriate level of care and, if appropriate, to certify medical necessity for residential treatment services. Membership and qualifications of the team are also stipulated in 42 CFR § 441.153. Historically, DMAS has not required the certification teams to be enrolled providers and did not reimburse the certification teams for their services.

Effective July 1, 2017, DMAS requires that all certification teams are credentialed and contracted with Magellan in order to administer the independent certification process on behalf of DMAS. The new certification teams will be called the Independent Assessment, Certification and Coordination Team (IACCT) and the team will enhance the current certification process by:

- Ensuring care coordination and higher probability for improved outcomes;
- Following strict turnaround timeframes for assessing the need for treatment and level of care requirements;

- Accessing the established Medicaid grievance process as mandated by the Centers for Medicare and Medicaid Services (CMS);
- Ensuring freedom of choice in service providers as mandated by CMS; and
- Implementing Medical Necessity Criteria for all members who request residential care.

Medicaid-eligible youth must be referred to Magellan, to initiate referral to the IACCT team for PRTF and therapeutic group home services. In addition, all inpatient providers and residential treatment providers must refer to Magellan to initiate the IACCT certification process to assess and certify an appropriate level of care prior to being transferred to residential treatment or therapeutic group home care from an inpatient setting and when any individual has a need for transfer to a different residential level of care. All IACCT decisions are due within 10 business days of the referral to Magellan. A licensed mental health professional who is part of the IACCT, will conduct a diagnostic assessment through a face-to-face meeting and the IACCT will determine the appropriate level of care.

The IACCT is essential in ensuring the most clinically appropriate, least restrictive setting, and that care is provided in a manner that best suits the needs of each youth and family. The IACCT will also ensure family engagement in the decision making process and throughout the course of treatment.

**Medical Necessity Changes**

Effective July 1, 2017, Psychiatric Residential Treatment Services and Therapeutic Group Home services including those served in the EPSDT Program will begin using different Medical Necessity Criteria defined in the new Residential Treatment Services Manual. Magellan will stop using the current medical necessity criteria for Psychiatric Residential Treatment Services, Therapeutic Group Homes and will instead make authorization decisions using the new medical necessity criteria and IACCT review process.

Authorizations will be issued using a maximum duration of 30 days per admission based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care.

The IACCT team will gather relevant information from which Magellan will use to render a medical necessity determination. The service review process used by Magellan will assess the plan of care and treatment plan to determine if the services are adequate to treat the individual's needs in the residential or group home setting. The Magellan review will focus more intensively on the quality of care for the member while in the residential service setting.

***Additional information and training resources including recorded information about the program changes and the IACCT process is available on the Magellan of Virginia website at: Residential Service Changes.***

***Questions about the IACCT process may be directed by email to: RTCChange@dmas.virginia.gov.***

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**MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)**

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please

contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

**MANAGED CARE PROGRAMS**

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC):
  http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

**COMMONWEALTH COORDINATED CARE PLUS**

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

**VIRGINIA MEDICAID WEB PORTAL**

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

**KEPRO PROVIDER PORTAL**

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

**"HELPLINE"**

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

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| 1-804-786-6273 | Richmond area and out-of-state long distance |
| 1-800-552-8627 | All other areas (in-state, toll-free long distance) |

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

**TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE**

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

**Attached Number of Pages: (1)**